



A REPORT
TO THE
MONTANA
LEGISLATURE

PERFORMANCE AUDIT

*Detection and Resolution
of Suspected Medicaid
Recipient Prescription
Fraud and Abuse*

*Department of Public Health and
Human Services*

MAY 2013

LEGISLATIVE AUDIT
DIVISION

12P-12

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PERFORMANCE AUDITS

Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Members of the performance audit staff hold degrees in disciplines appropriate to the audit process.

Performance audits are performed at the request of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

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May 2013

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the Department of Public Health and Human Services' activities related to the detection, investigation, and resolution of Medicaid recipient prescription fraud and abuse. This report presents audit findings and recommendations for the agency, including complying with federal regulations, improving direction provided to staff and contractors, and improving case tracking. A written response from the department is included at the end of the report.

We wish to express our appreciation to officials and staff at the Department of Public Health and Human Services, as well as to contracted staff, for their cooperation and assistance throughout the audit.

Respectfully submitted,

/s/ Tori Hunthausen

Tori Hunthausen, CPA
Legislative Auditor

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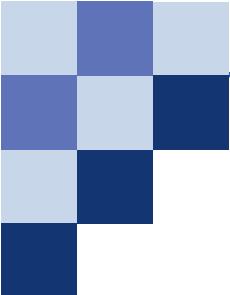
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MONTANA LEGISLATIVE AUDIT DIVISION

PERFORMANCE AUDIT

Detection and Resolution of Suspected Medicaid Recipient Prescription Fraud and Abuse

Department of Public Health and Human Services

MAY 2013

12P-12

REPORT SUMMARY

More than \$75 million was spent during fiscal year 2012 on Medicaid prescription drugs in Montana. The Department of Public Health and Human Services should comply with federal regulations and develop a process for detecting, identifying, and resolving suspected cases of recipient prescription fraud and abuse.

Context

Authorized by state and federal law, the Montana Medicaid Program is a joint federal-state program which provides medical coverage, including prescription benefits, to eligible Montanans. The program is administered by the state Department of Public Health and Human Services (department). As part of its obligations for administering Medicaid, the department is required by federal regulation to conduct specific duties related to fraud and abuse. Our audit focused on the department's activities related to identification, investigation, and resolution of potential prescription-related fraud and abuse by Medicaid recipients.

Results

Federal regulations mandate inclusion of a fraud detection and investigation program within state Medicaid programs. Additionally, state Medicaid agencies are required to have methods and criteria for identifying suspected fraud cases. Based on audit work, we determined the department is not in compliance with federal regulations and identified weaknesses in the department's controls related to prescription-related fraud and abuse.

While we determined the department and a contractor analyze prescription claim data, we found no formal process for tracking cases identified through this analysis. In addition, we reviewed administration of a department hotline promoted as a hotline available to receive information about Medicaid recipient fraud or abuse. We determined the hotline is not an effective mechanism for identifying potential recipient fraud or abuse and improvements in its administration are needed.

We also sought to determine if the department effectively investigates and resolves cases of suspected prescription-related fraud or abuse in a manner which complies with state and federal requirements. We selected a sample of 31 potential cases to assess department efforts in this area. We found the department has a limited process for investigating these types of cases. Additionally, we determined the department has no process for referral of cases to law enforcement. In our sample, we noted allegations of illegal activity by recipients related to prescription drug diversion and "doctor-pharmacy shopping." None of the cases in our sample were referred

(continued on back)

to appropriate law enforcement. Additionally, we reviewed the department's internal monitoring of recipients identified as having inappropriate or excessive use of prescription services. We noted weaknesses related to how the department tracks these recipients.

To address these concerns and others, we make eight recommendations to the department to comply with federal regulations and develop a process for detecting, identifying, and resolving cases of suspected prescription fraud and abuse in the Medicaid program.

Recommendation Concurrence	
Concur	8
Partially Concur	0
Do Not Concur	0

Source: Agency audit response included in final report.

For a complete copy of the report (12P-12) or for further information, contact the Legislative Audit Division at 406-444-3122; e-mail to lad@mt.gov; or check the web site at <http://leg.mt.gov/audit>

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Chapter I – Introduction

Introduction

Authorized by state and federal law, the Montana Medicaid Program (Medicaid) is a joint federal-state program which provides medical coverage, including prescription coverage, to eligible Montanans. The program is administered by the state Department of Public Health and Human Services (department), in partnership with the federal Centers for Medicare and Medicaid Services (CMS). As part of its obligations for administering Medicaid, the department is required by federal regulation to conduct specific duties related to fraud and abuse. The Legislative Audit Committee requested a performance audit of the department's controls over Medicaid prescription fraud and abuse.

Audit Objectives

Based on our initial assessment of the department's activities related to Medicaid prescription fraud and abuse, we developed two audit objectives:

1. Determine if the department has effective controls in place to detect potential prescription fraud or abuse committed by Medicaid recipients.
2. Determine if the department effectively investigates and resolves potential prescription fraud or abuse committed by Medicaid recipients in a manner which complies with state and federal requirements.

Audit Scope and Methodologies

As noted in our audit objectives, audit scope focused on the department's activities related to the detection, investigation, and resolution of cases of prescription fraud or abuse committed by Medicaid recipients. We specifically reviewed actions taken by the department to identify Medicaid recipients having a history of inappropriate or excessive use of prescription services and how the department investigated and resolved potential fraud or abuse. We did not review department controls to prevent fraudulent or abusive claims from being approved. Generally, we reviewed activities occurring during state fiscal year 2012.

We did not examine department handling of fraud or abuse cases involving medical providers, pharmacies, or drug manufacturers. Further, while we reviewed some work completed by two department contractors related to the overall handling of cases of suspected prescription fraud or abuse committed by Medicaid recipients, we did not assess the department's general management of these contracts.

To address our audit objectives, we completed the following methodologies:

- ◆ Reviewed federal law and regulations regarding state Medicaid agency requirements related to the handling of recipient prescription fraud or abuse.
- ◆ Reviewed Montana's State Medicaid plan.
- ◆ Reviewed related Montana statute and administrative rules.
- ◆ Identified criteria and guidance from CMS and Medicaid agencies in other states.
- ◆ Identified sources of criteria from other Montana agencies related to the handling of fraud or abuse committed by program beneficiaries.
- ◆ Interviewed department and contract staff and reviewed department policies and procedures regarding roles and responsibilities for detecting, investigating, and resolving potential prescription fraud or abuse committed by Medicaid recipients, as well as the methods for doing so.
- ◆ Reviewed the reporting function used by department and contract staff for extracting data about Medicaid prescription claims.
- ◆ Reviewed Medicaid prescription claims denied during state fiscal year 2012.
- ◆ Examined department mechanisms in place for receiving tips, complaints, or referrals about potential prescription fraud or abuse committed by Medicaid recipients.
- ◆ Reviewed department and contractor files for a sample of cases of potential recipient prescription fraud or abuse to assess resolution of these cases.

Areas for Further Study

During the course of this audit, we identified two areas for consideration for future performance audit work.

Prescription Drug Card System

The Prescription Drug Card System (PDCS) is an online, real-time system used by enrolled pharmacy providers to submit prescription claims to the Medicaid and Mental Health Services Programs. For each claim, the PDCS electronically verifies recipient eligibility and product coverage status; identifies applicable copayment requirements; applies prospective drug utilization review (Pro-DUR) edits; and adjudicates the claim. The PDCS is owned and operated by a contractor and is an enhancement to the department's contract for the Medicaid Management Information System (MMIS). In addition to the department, there are several other government and private users of the PDCS. Department staff report the Pro-DUR and other edits in the PDCS serve as the primary defense mechanism for preventing prescription fraud and abuse. An information systems audit could assess the data contained in the PDCS and determine if the system is operating as intended.

Team Care Program Administration

State Medicaid programs may request from CMS waivers of certain Medicaid requirements mandated by federal law. Under a §1915 (b) waiver, the Managed Care Bureau within the department's Health Resources Division operates the Team Care program as part of the Medicaid program. It is for individuals identified through claims review, DUR referrals, or provider referrals as having inappropriate or excessive use of health care services. Individuals are enrolled in Team Care for at least 24 months, during which they are required to receive services from one specific medical provider and one specific pharmacy. A performance audit could evaluate the effectiveness of the program at mitigating inappropriate or excessive use of health care services by Medicaid recipients, as well as assess the department's administration of the program.

Report Contents

The remainder of this report includes a background chapter, followed by chapters detailing our findings and recommendations in the following areas:

- ◆ Chapter III presents recommendations for complying with federal regulations and improving the effectiveness of the department's mechanisms for identifying cases of potential recipient prescription fraud and abuse.
- ◆ Chapter IV discusses establishment of formal processes by the department for investigation and resolution of cases of recipient prescription fraud and abuse.
- ◆ Chapter V presents information on the department's overall management of activities related to the handling of cases of potential Medicaid recipient prescription fraud or abuse.

Chapter II - Background

Introduction

As discussed in the previous chapter, the Montana Medicaid Program (Medicaid) is administered by the Department of Public Health and Human Services (department) in partnership with the federal Centers for Medicare and Medicaid Services (CMS). The Health Resources Division (HRD), which is in the Medicaid and Health Services Branch, provides administration, policy development, and reimbursement for the primary and acute care portions of the Medicaid program, which includes the Prescription Drug Program.

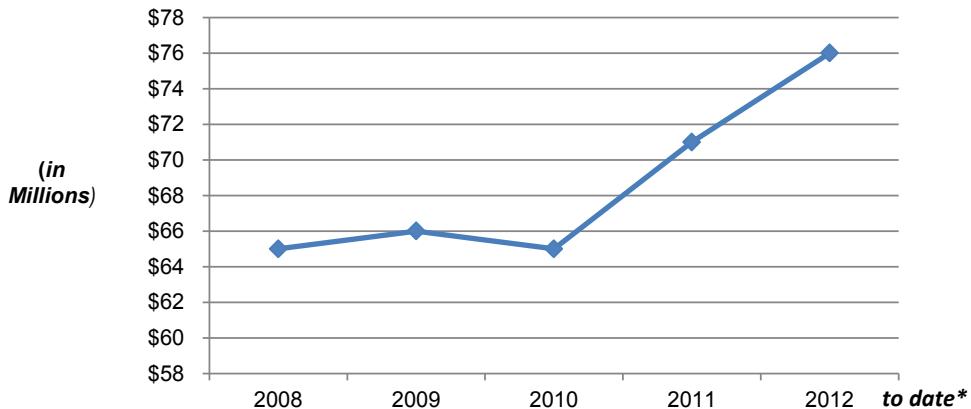
The Medicaid program provides medical coverage for a number of different groups and populations in Montana who meet eligibility requirements. The benefits provided by Medicaid must meet federal requirements. These include, but are not limited to, physician care, laboratory and x-ray services, hospital care, and services at rural health clinics. In addition to these mandatory services, there are other services which are optional for states to cover. While prescription drug coverage falls in this category, all states have elected to provide this coverage.

The remainder of this chapter describes the Medicaid Prescription Drug Program, as well as the role of two contractors whose services directly relate to the administration of that program. At the end of the chapter, we provide an informational chart meant to clarify the overall Medicaid prescription process and the entities involved, as well as information about federal limitations for handling cases of abuse.

Medicaid Prescription Drug Program

The Medicaid Prescription Drug Program is administered by HRD's Acute Services Bureau (ASB). Two program staff are responsible for development, administration, and operation of the program; coordinating with the Drug Utilization Review (DUR) Board; and monitoring and identifying issues within the pharmaceutical industry and recommending appropriate Prescription Drug Card System (PDCS) edits and pharmacy program policy. The program provides coverage for an increasing number of prescriptions each year. In the last five fiscal years, the program's expenditures have increased by over 17 percent. Figure 1 shows the department's prescription drug expenditures for fiscal years 2008 through 2012.

Figure 1
Medicaid Prescription Expenditures
 FY 2008 through 2012



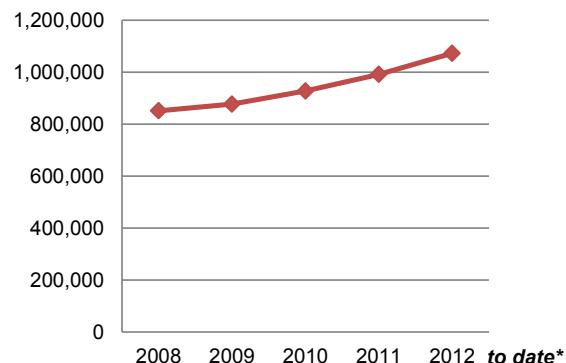
*2012 claims may be submitted until June 30, 2013.

Source: Compiled by the Legislative Audit Division from Legislative Fiscal Division and department records.

Pharmacy services are reimbursed under a fee-for-service methodology in which pharmacies receive both a dispensing fee for each prescription and the cost of the prescription ingredients. Drug coverage is limited to those products where the pharmaceutical manufacturer has signed a rebate agreement with the federal government. In addition, federal law allows state Medicaid programs to impose restrictions on payment for prescription drugs through a preferred drug list (PDL). Through its PDL, the department has identified “preferred” drugs for which it will provide coverage based on clinical efficacy and cost.

Claims processing for Medicaid pharmacy services is done on a real-time, point-of-sale basis. As discussed earlier in this report, the PDCS processes prescription claims electronically based on recipient eligibility, product coverage status, and DUR requirements and limitations. Claims may also be submitted up to 365 days from the date of service, retroactive eligibility is determined, disability is determined, or within six months of the date Medicare pays its portion of the claim. This is known as retroactive billing. Figure 2 shows the number of Medicaid prescription claims paid since 2008.

Figure 2
Number of Medicaid Prescription Claims Paid
 FY 2008 through 2012



*2012 claims may be submitted until June 30, 2013.

Source: Compiled by the Legislative Audit Division from department records.

Medicaid Pharmacy Contractors

In its delivery of Medicaid pharmacy benefits, the department works in coordination with two contractors. The following section provides a description of the two contractors and the services provided by both.

Medicaid Management Information System Contractor

One contractor provides fiscal agent operations of the Medicaid Management Information System (MMIS), of which the PDCS is a part. Throughout this report, this contractor will be referred to as the MMIS contractor. Under this contract, the MMIS contractor completes a wide variety of duties including:

- ◆ Provider enrollment, including verification of licensure and certification information and status.
- ◆ Provider relations, including response to inquiries, support regarding pending and denied claims, and provision of provider manuals.
- ◆ Medical and prescription claims adjudication and payment.
- ◆ Operation of a toll-free telephone number available for Medicaid providers and recipients for inquiries related to coverage, claims processing, eligibility, and a number of other issues.

DUR Contractor

The second contractor has two contracts with the department related to Medicaid prescriptions. The first contract is for drug prior authorization (PA) services and the second contract is for DUR services. Throughout the remainder of this report, this contractor will be referred to as the DUR contractor. Under the PA contract, the DUR contractor reviews requests from healthcare providers for authorization of certain prescription drugs and home infusion therapies for Medicaid recipients, based on criteria established by the department in conjunction with the DUR Board. In order to handle PA requests, the DUR contractor operates a call center staffed by licensed pharmacists and pharmacy technicians. The call center receives approximately 2,500 PA requests per month and an additional 600 ancillary calls related to informational requests and PDCS performance issues.

As noted, the DUR contractor's second prescription-related contract with the department is for DUR services. This includes operation of the DUR Board, as well as retrospective and prospective DUR. The DUR Board is composed of medical providers and pharmacists and provides oversight of DUR activities and serves in an advisory role regarding educational outreach activities offered by the DUR contractor to medical providers, pharmacies, and recipients. Through retrospective DUR, the

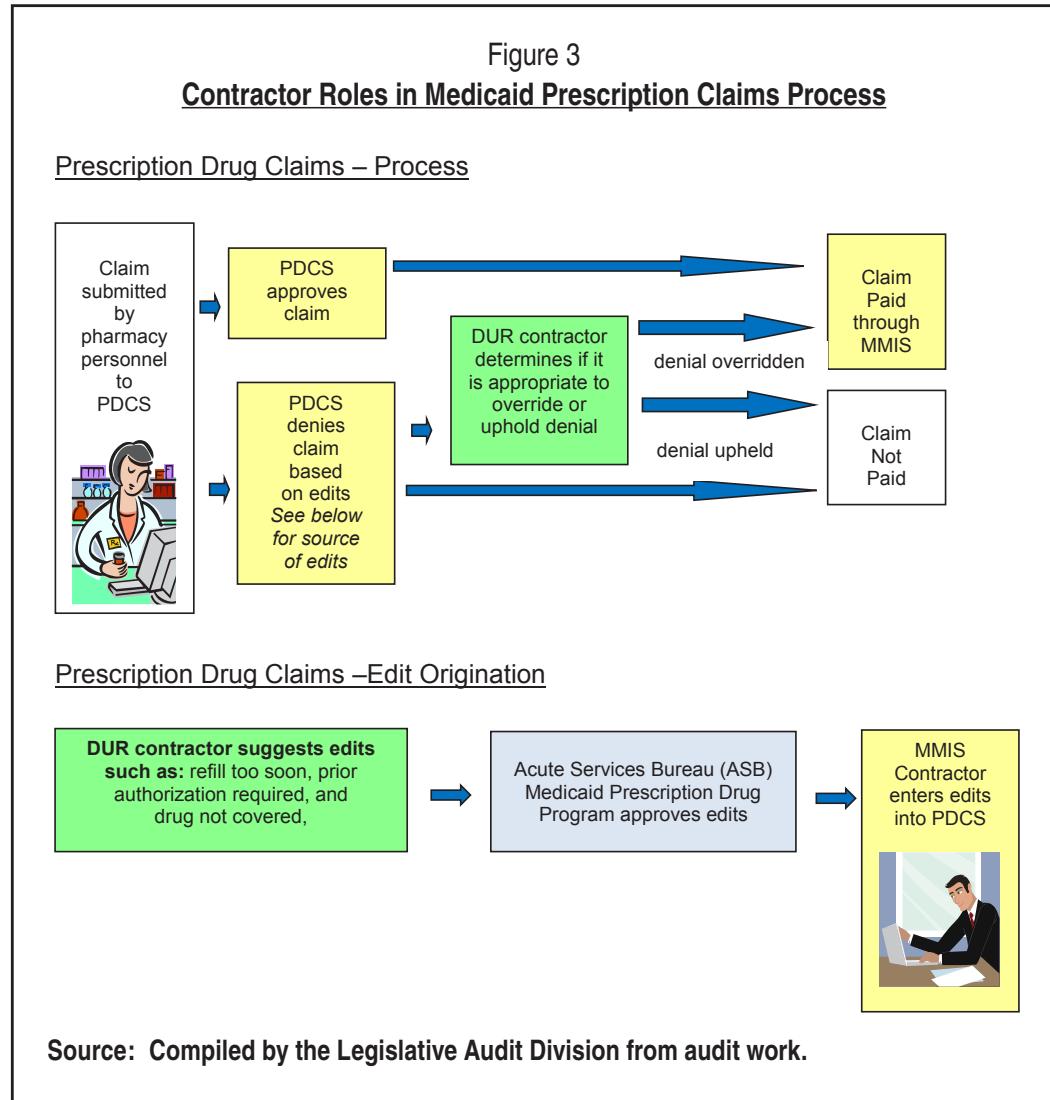
DUR contractor reviews pharmacy claims paid and denied after the billing takes place, facilitating the development of prospective drug utilization edits, facilitates provider and client intervention, or education as necessary. Prospective DUR of Medicaid pharmacy claims is conducted at the time a claim is submitted. This is done by the PDCS, using system edits which approve or deny the claim. These edits are developed by the department, in conjunction with the DUR Board, based on information from retrospective DUR activities, current medical literature, and federal standards. The edits prevent adverse reactions for a recipient based on their medical history and other drugs the recipient may be taking. Additionally, early refill edits prevent recipients from receiving a refill of a prescription prior to specific dates, based on the directions on the prescription and the number of days for which supplied. Quantity limits prevent filling prescriptions that would provide too high of dosages. Other prospective clinical edits require prior authorization for drugs that have unique qualities or may be subject to abuse.

The Pharmacy Case Management Program is a component of the DUR contract and is a medication management program in which the contractor reviews Medicaid recipient claims and health information and consults with the recipient's medical provider in order to achieve better medical outcomes. The program was designed to identify recipients who are high utilizers or whose drug therapy does not correspond with their health condition.

Once a recipient has been selected for review, their drug claims data and diagnosis information is reviewed to identify possible medication over-usage, medication duplication, potential interaction between drugs, drug-disease indications, identification of the use of multiple medical providers or pharmacies, or potential cost savings recommendations. Issues identified are documented in the DUR contractor's information system. If some sort of intervention is deemed appropriate, an informational letter is sent to the recipient's medical provider and a conference (billable to Medicaid) is requested. If necessary, the recipient may be referred to the department's Team Care program or, if the medical provider requests it, the DUR contractor may enter a "drug not covered" edit into the PDCS which limits the recipient's access to all controlled substances unless approved by that medical provider. Once the determined intervention has been instituted, the recipient is not reviewed again unless they are re-identified for case management services.

Medicaid Prescription Process

Figure 3 shows the role of the MMIS and DUR contractors in the process undergone by a Medicaid prescription drug claim:



Federal Limitations for Resolving Medicaid Abuse

As will be discussed later in this report, federal regulations are specific as to how Medicaid agencies are to handle instances of fraud in the Medicaid program—these cases must be referred to appropriate law enforcement. The department's options for handling cases of suspected abuse are equally specific and do not include removal of the recipient from the program. Because the Medicaid program is an entitlement program, recipients cannot be removed from the program unless they no longer meet

eligibility requirements. While there are sanctions available to the department in response to recipient abuse of the Medicaid program, discontinuation of Medicaid coverage because of recipient abuse is not allowed.

Chapter III – Department Detection of Recipient Prescription Fraud and Abuse

Introduction

Under the authority of the Social Security Act, the Code of Federal Regulations requires the inclusion of a fraud detection and investigation program within state Medicaid programs. Under 42 CFR §455.13 state Medicaid agencies are required to have methods and criteria for identifying suspected fraud cases. One of our objectives was to determine if the Department of Public Health and Human Services (department) has effective controls in place to detect potential prescription fraud or abuse committed by Medicaid recipients. Based on audit work, we identified areas where the department can enhance its efforts in this area. Audit findings and recommendations related to the following areas are discussed in this chapter:

- ◆ Compiling information related to potential fraud and abuse which results from the analysis of prescription claim information.
- ◆ Administration of the Medicaid recipient fraud hotline.

Analysis of Prescription Claim Information as Method for Detecting Fraud and Abuse

The analysis of prescription claim records is one method for detecting fraud and abuse. During the course of this audit, we examined how the department uses prescription claim information from the Prescription Drug Card System (PDCS) to identify data anomalies and trends which may indicate potential recipient fraud or abuse. We identified two means by which information about prescription claims is extracted from the PDCS (standard and ad hoc reporting functions) and reviewed how the department uses these tools.

Department Review of Claims

The department and its contractors use both standard and ad hoc reporting to obtain information about Medicaid prescription claims. A standard series of reports is generated on a monthly basis by the Medicaid Management Information System (MMIS) contractor. These reports are useful for general, high-level program administration and generally contain only summary information about prescription claim activity for the previous month, such as pharmacies paid the most; drugs prescribed and dispensed most frequently; the average number and cost of prescriptions dispensed per recipient; and the total number of claims submitted, paid, and denied. In addition, there are reports containing recipient-specific information related to the 100 recipients using the largest number of prescriptions and whose prescriptions were the most expensive.

The drug utilization review (DUR) contractor also reviews claim information based on standard DUR indicators, such as therapeutic duplication, interactions between multiple drugs, or recipients using multiple pharmacies or medical providers. This is meant to identify recipients at high risk for drug therapy complications and provides educational intervention to physicians and pharmacists. The purpose is to achieve appropriate and cost-effective use of prescriptions by identifying and reducing the frequency of patterns of inappropriate or medicinally unnecessary care. Management for the DUR contractor reported those clients representing the highest risk in terms of the standard indicators are further reviewed each month.

The second means for extracting information from the PDCS about prescription claims is through the ad hoc reporting function. These reports are generated by users of the system, including the department and staff from the MMIS and DUR contractors. According to system users, ad hoc reports may be generated for a number of reasons, including requests for information by internal or external parties, inquiry into data anomalies, determination of whether trends reported in other states are present in Montana, and completion of DUR-related analysis.

Documentation and Compilation of Information Resulting from Data Analysis Is Limited

While the department and its contractor review claims information, there are limitations to the documentation and compilation of information regarding its data analysis. During audit work, we determined the department has no central documentation of anomalies and trends which may indicate potential prescription-related fraud or abuse. Additionally, we found no documentation regarding whether data analysis anomalies were further reviewed to identify if potential fraud or abuse had occurred. While the DUR contractor provides monthly reports to the department listing recipients reviewed during the month, the list does not provide specific details regarding whether the case is considered potential fraud or abuse.

Examples of Information Tracking Are Available

Within the department, we identified examples where staff review claims specifically for the purpose of identifying potential fraud or abuse committed by Medicaid providers and record their efforts formally. The Surveillance and Utilization Review Section (SURS) within the department's Quality Assurance Division is responsible for protecting the integrity of Medicaid from fraud and abuse. While SURS' focus is on fraud and abuse, staff in that section focus on the actions of Medicaid providers, not recipients. Staff query Medicaid data and maintain a record of the queries completed

so staff are aware of what information has already been reviewed. Cases resulting from queries are documented in a formal case file containing information such as:

- The reason why case was opened.
- The exact query language so the report may be replicated.
- Information about individuals or businesses involved.
- Correspondence related to the case.

Lack of Case Tracking May Impact Investigation and Resolution

Specific federal regulations governing the handling of cases of potential fraud and abuse by Medicaid recipients exist. In order to meet its responsibilities in these areas, the department should enhance its data analysis process to ensure its review of data anomalies and trends is appropriately documented and compiled. The department should take steps to compile this information to show when specific reports are run, the exact query language used, and trending information from the past. By improving its process, the department will be better able to ensure and demonstrate compliance with federal and state regulations. Additionally, the department will also have a more complete case file to better justify formal action taken against the recipient if fraud or abuse occurred.

RECOMMENDATION #1

We recommend the Department of Public Health and Human Services make improvements to its data analysis process by documenting and compiling trends and anomalies which may indicate potential prescription-related fraud or abuse.

Federal Law Requires Mechanism to Receive Reports of Fraud and Abuse

Federal law requires state Medicaid agencies to provide a mechanism to receive reports from recipients and others concerning alleged instances of waste, fraud, and abuse. Additionally, states are required to compile data on the reports received via that mechanism. As part of our review, we examined the department's compliance with this law.

In the course of our work, we sought to identify the means by which the public and other parties may report instances of potential prescription fraud or abuse by Medicaid

recipients. In order to do so, we reviewed the department's website and publications. We identified a single advertised mechanism for reporting of Medicaid recipient fraud or abuse not related to eligibility for the program. That mechanism is a toll-free hotline listed on the department's website for reporting fraud or abuse related to all types of Medicaid services, not only prescription services. There is no mention of the hotline or any of the department's other activities related to fraud or abuse on the department's main web page. We determined the hotline was listed on the individual websites of multiple divisions and programs within department; however, in our review, we found different telephone numbers listed for the hotline. Department staff confirmed the number on one website was wrong and the information was subsequently corrected.

During audit work, we determined the telephone number listed for the hotline is the same telephone number as the "Medicaid Recipient Help Line." This telephone number is operated and staffed by the MMIS contractor and is listed as a resource for recipients to get information about topics such as Medicaid coverage, eligibility for services, and provider billing. We called the number to assess the ease of reporting potential fraud or abuse. When the number is called, an automated system answers and the script at right is read. We found there is no identification that the hotline is a mechanism for reporting fraud or abuse and there is no option listed for callers who are neither a Medicaid provider nor client.

Medicaid Recipient Help Line

"Welcome to the Montana Medicaid and Healthy Montana Kids Plus Helpline. Your call will be recorded for quality assurance. If you are a provider, press 2. If you are a Montana Medicaid client, please press 1."

Depending on which of the two options the caller selects, the call is routed to one of two different staff groups. One group's primary duty is to answer questions from providers, while the other's is to answer questions from Medicaid recipients. Information about each call is logged in an information system maintained by the MMIS contractor.

Medicaid Recipient Fraud Hotline Not an Effective Mechanism for Identifying Potential Fraud or Abuse

Management at the MMIS contractor reported they are unable to determine the exact number of calls received or to identify which specific calls were related to fraud or abuse. Though calls are logged, information about the specifics of the calls is recorded in a "notes" section. Because of the way it is entered, the information is not searchable and there is no way to generate a report of fraud- or abuse-related calls. Additionally, the MMIS contractor has no means for determining how these calls were handled, including whether the caller was directed to call another number or if staff communicated call information to the department. While management believes the

hotline only receives two to three calls per month related to any type of fraud or abuse, it is impossible to determine the actual number for fiscal year 2012 or any other time period.

Management reported the employees staffing this hotline receive no training related to fraud or abuse, including training about the types of questions to ask callers or how call information should be documented. It was also noted staff have access to internal desktop procedures which instruct staff to refer callers with information about fraud to the Department of Justice's Medicaid Fraud Control Unit (MFCU). When we obtained the desktop procedures, we found staff were directed to refer callers not to MFCU, but to the department's Program Integrity (PI) section. However, PI staff indicated they had very little to do with Medicaid, but were, instead, focused on eligibility-related issues associated with other department programs.

Department Required to Report Instances of Potential Fraud

As the state Medicaid agency, responsibility for providing a mechanism to receive reports from recipients and others regarding alleged instances of waste, fraud, and abuse and compiling related information lies with the department. In addition, state law requires state agencies to report to the attorney general and legislative auditor instances of theft, actual or suspected, involving state funds for which the agency is responsible. While operation of the department's Medicaid recipient fraud hotline is currently conducted by the MMIS contractor, primary responsibility for addressing concerns identified through the hotline falls to the department.

Improvements Should Be Made in Hotline Administration

While the total extent of healthcare fraud is unknown, it is estimated to be in the billions of dollars nationwide each year. Studies show hotlines are a leading source for fraud, waste, and abuse detection. As the department's hotline is currently administered, it is not an effective mechanism for identifying cases of potential fraud and abuse. Therefore, it is necessary for the department to develop a clear and consistent approach to administration of its hotline.

RECOMMENDATION #2

We recommend the Department of Public Health and Human Services increase effectiveness of the Medicaid recipient fraud hotline and ensure:

- A. *The hotline is appropriately advertised to potential users.*
- B. *Staff administering the hotline are trained to identify potential fraud and abuse.*
- C. *Call information is effectively recorded and compiled.*
- D. *Issues identified through hotline reports are resolved appropriately, based on state and federal regulations.*

Chapter IV – Investigation and Resolution of Recipient Prescription Fraud and Abuse

Introduction

The previous chapter discussed improvements in the department's mechanisms for actively identifying cases of recipient prescription fraud and abuse, as well as handling reports received from outside parties. Federal regulations provide requirements regarding identification of suspected fraud cases, but there are also requirements for investigation and resolution of these types of cases. Our second objective was to determine if the Department of Public Health and Human Services (department) effectively investigates and resolves these cases in a manner which complies with state and federal requirements. Based on audit work, we identified areas where improvements are needed. This chapter discusses audit findings and recommendations related to the following areas:

- ◆ Investigation of identified cases of possible prescription fraud or abuse committed by recipients.
- ◆ Resolution of those cases.
- ◆ Consistent case tracking.

Preliminary and Full Investigation of Cases Is Required

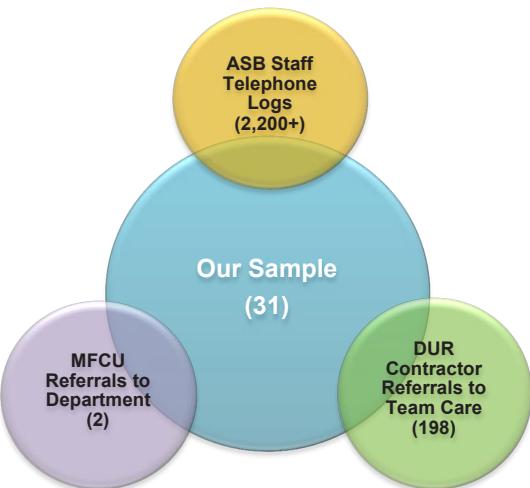
Under 42 CFR §455.14, if a Medicaid agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is a sufficient basis to believe an incident of fraud or abuse has occurred. If there is reason to believe a recipient has defrauded Medicaid, the state Medicaid agency must refer the case to an appropriate law enforcement agency. If there is reason to believe a recipient has abused the Medicaid program the agency must conduct a full investigation of the abuse.

Department Investigation of Cases Does Not Comply With Federal Regulation

As part of our audit, we consulted with department and contracted staff in order to develop criteria regarding the types of recipient behavior which would be considered suspicious or indicative of possible fraud or abuse. We then tested a sample of cases of potential prescription fraud or abuse to assess how the department investigates these types of cases.

As discussed in the previous chapter, during this audit we determined the department does not maintain documentation of cases of potential recipient prescription fraud

Figure 4
Selection of Audit Sample



Source: Compiled by the Legislative Audit Division from department records

or abuse. In order to review the department's handling of identified cases, we selected 31 cases from three sources, shown in Figure 4. Because department staff reported allegations of potential fraud or abuse by recipients would likely be referred directly to Acute Services Bureau (ASB) staff, we reviewed staff telephone logs for fiscal year 2012. Out of over 2,200 telephone calls logged by staff, we identified ten calls in which the call log information appeared to indicate potentially fraudulent or abusive behavior by specific recipients. Our second sample source was information

about recipients referred to the Team Care program by its drug utilization review (DUR) contractor as the result of the DUR or prior authorization activities. Because individuals enrolled in the Team Care program are those who have been identified as having inappropriate or excessive use of health care services, we concluded these referrals represented individuals who were higher risk in terms of potential prescription fraud or abuse. We randomly selected nineteen recipients referred to Team Care. The final source for our sample were cases referred to the department by the Department of Justice's Medicaid Fraud Control Unit (MFCU) during fiscal year 2012 which pertained to cases of potential prescription-related fraud or abuse by Medicaid recipients. We identified two such cases and both were included in our final sample.

We reviewed information from the department and both the MMIS and DUR contractors about the recipients included in our sample. This information related to Team Care, DUR, or pharmacy case management activities, as well as the recipients' prescription claim histories. Based on the criteria developed regarding the types of recipient behavior which would be considered suspicious or indicative of possible fraud or abuse, we identified recipients who should have been subject to a preliminary investigation to determine if fraud or abuse occurred, as required by federal regulation. The case notes and department records about these recipients indicated the department or its contractors were aware of allegations the recipients had committed potentially

fraudulent or abusive behavior which should have been looked into further. These allegations identified questionable behavior related to:

- ◆ Over-utilization of prescription drugs.
- ◆ Reported doctor and pharmacy “shopping.”
- ◆ Diversion of prescription drugs to other users.
- ◆ Cash-paying for narcotics.

Based on our review, we identified no evidence that either a preliminary or full investigation had occurred in any of the cases we reviewed. We did find that, through its work related to DUR and prescription prior authorization, the DUR contractor reviews recipient usage and claim history and identifies appropriate interventions. However, based on our review of federal regulations, the purpose of the preliminary investigation is for the Medicaid agency to make a decision about whether fraud or abuse has occurred. This decision dictates the options allowed for case resolution. During our audit, we found no evidence of an investigatory process which would facilitate this decision or documentation supporting the final course of action.

Examples and Tools for Investigation Are Available

During the course of our work, we identified examples of investigation and tools available to the department to aid in case investigation. When an allegation of eligibility-related fraud or abuse is reported to the department’s Program Integrity (PI) Section, staff conduct an initial review to determine if the allegation could be true. If it is determined the case should be reviewed further, a formal case is opened and full investigation is conducted to determine if the fraud or abuse actually occurred and the resulting costs to the department. The Department of Justice’s MFCU has a similar process. Formal policy for that unit states upon receipt of a case referral, investigators should gather relevant preliminary information through actions such as:

- ◆ Review of Medicaid eligibility and billing exposure.
- ◆ Follow-up with local law enforcement to see if they are already involved with the case.
- ◆ Determination of MFCU jurisdiction over the case.

An additional tool we noted which may be helpful to the department as it investigates cases of potential prescription fraud or abuse by Medicaid recipients is the Department of Labor and Industry’s Montana Prescription Drug Registry. The 2011 Montana Legislature authorized the Board of Pharmacy to develop, implement, and operate the registry and the goal is to assist health care providers in offering safe and effective treatment for their patients, and to identify and inhibit the diversion of controlled substances. The department has been involved with the development of the registry.

The registry has been operational since November 2012 and contains a listing of all outpatient prescriptions for controlled substances dispensed in Montana. Use of the registry is limited to medical providers and pharmacists; however, department staff and the DUR contractor do have access to the registry. Though the registry is relatively new, both department and contract staff report using it to access information about recipient usage. As the department develops its processes for investigating these types of cases, more formal use of the registry could be incorporated.

Department Has No Formal Process for Investigating Questionable Behavior by Medicaid Recipients

In discussion during the audit, department management acknowledged there is no formal process for the investigation of cases of potential prescription fraud or abuse committed by Medicaid recipients and no clear guidance has been provided to either department or contracted staff regarding their role and responsibilities in this area. There is risk associated with an investigatory process which is not conducive to the department's determination of whether recipient fraud or abuse has occurred. In addition to noncompliance with federal regulations, there is risk of increased costs to Medicaid. Further, there are increased risks to public safety in instances where Medicaid recipients divert prescription drugs to other users through sharing or sales. Formal investigation of these types of cases would benefit the department by mitigating these risks.

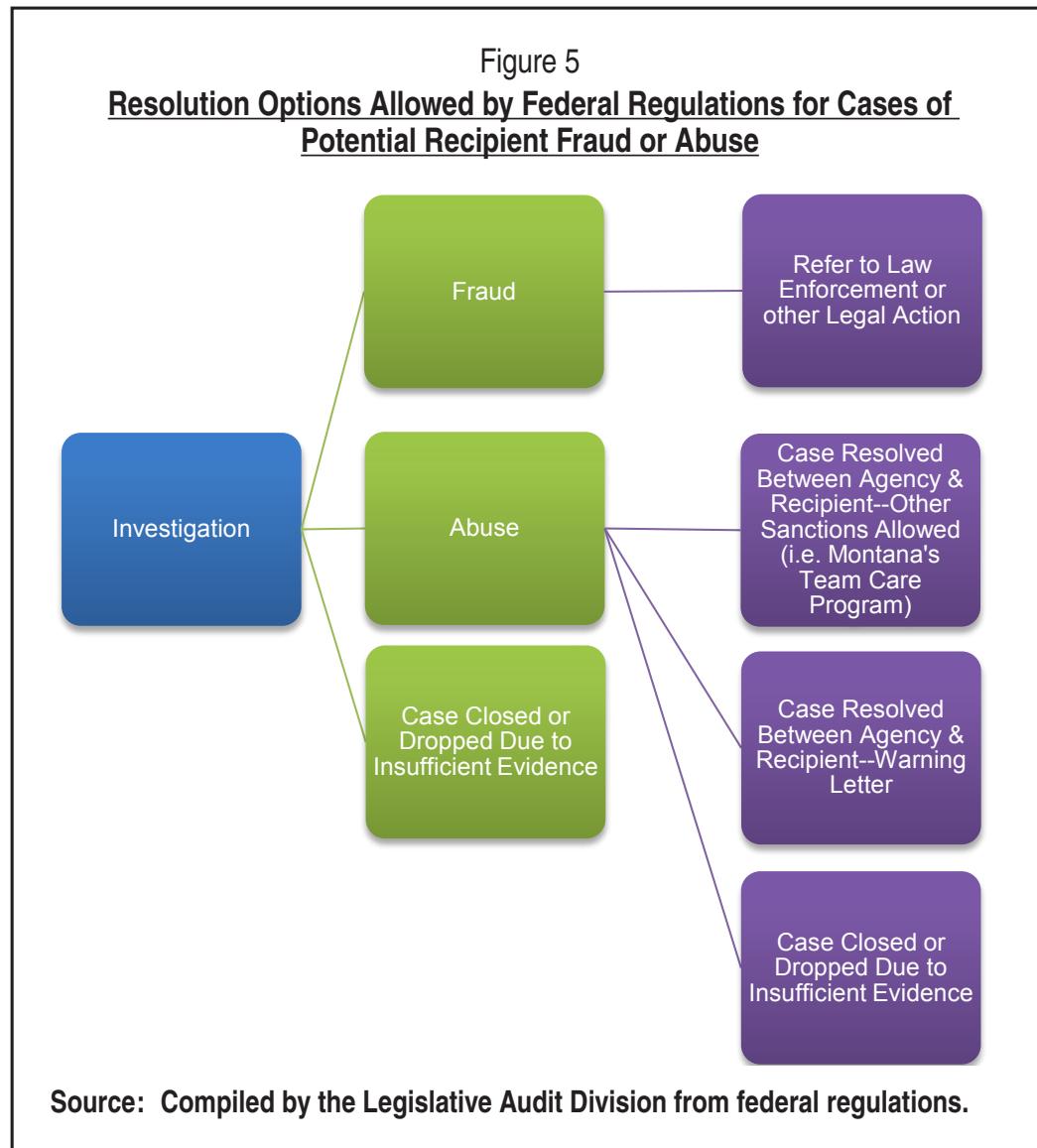
RECOMMENDATION #3

We recommend the Department of Public Health and Human Services comply with federal regulations and conduct preliminary and full investigations of cases of potential recipient prescription fraud or abuse.

Resolution of Cases of Recipient Fraud or Abuse

As they do with regard to investigation of cases of potential fraud or abuse committed by Medicaid recipients, federal regulations provide clear guidance on the resolution of these cases. Figure 5 shows avenues of resolution available to state Medicaid agencies. As stated, if, as the result of a preliminary investigation, a state Medicaid agency has reason to believe a Medicaid recipient has defrauded the program, the case must be referred to an appropriate law enforcement agency. If a state Medicaid agency believes a recipient has abused the Medicaid program, 42 CFR §455.15 requires a full investigation must be conducted until the case is resolved either because of insufficient

evidence or an internal resolution between the Medicaid agency and recipient is reached. During this audit, we reviewed the cases included in our sample to determine how each was resolved.



Department Does Not Refer Cases of Prescription Fraud to Law Enforcement

Federal regulations define fraud as an intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to the individual or some other person. It includes any act which constitutes fraud under applicable state or federal law. In our review of 31 cases, we identified eleven cases of potential doctor or pharmacy “shopping.” This is when a person sees

multiple providers and pharmacies in a short amount of time in order to obtain multiple prescriptions for the same or similar drugs. This is specifically prohibited by §45-9-104 (6-7), MCA, which is the statute defining the crime of fraudulently obtaining dangerous drugs. In one of the cases in our sample, the recipient obtained 321 hydrocodone tablets in a 32-day time period from ten medical providers and five pharmacies. Pharmacy staff with the DUR contractor reported this is not a medically appropriate amount of the drug. In addition, we identified four cases in which there were noted allegations the recipient was diverting their prescription drugs to others, either by sharing with family members or selling. This is specifically prohibited by §45-9-101, MCA, which is the statute defining the crime of criminal distribution of dangerous drugs. In all of these cases, we saw evidence that the issues in question were identified by either the department or the DUR contractor, and steps were taken to appropriately manage each case medically. However, we found no evidence the department referred any of these cases to law enforcement, and we believe referral to law enforcement was appropriate.

Department Has No Procedures for Law Enforcement Referral

Based on our review of department policies and discussions with department management, we determined the department has no formal policy regarding which cases should be referred to appropriate law enforcement or how it should be done. Additionally, we identified misconceptions by department staff about which entities might handle cases such as these. In numerous instances, staff reported that in the event they encountered cases such as those identified above, the cases would be referred to either MFCU or the department's PI Section. However, because MFCU has no jurisdiction over recipient cases and the PI Section's focus is on eligibility offenses related to other programs, neither of these entities represents an appropriate law enforcement agency.

The department's lack of action in this area represents noncompliance with federal regulation and increases risk to the state and general public because it is paying for prescription drugs which are potentially being sold illegally by Medicaid recipients. Department management acknowledged their responsibility for referral of cases such as those discussed above to law enforcement and that they had no process for doing so. It was noted by department management that, in the past, when the department has referred cases to local law enforcement or county attorneys, no legal action resulted. They believe this may contribute to why cases are not referred. Regardless, the department is required to refer cases believed to be fraud to law enforcement and should implement procedures for doing so. Additionally, and to address department concerns of local law enforcement or county attorneys not pursuing cases referred, the

department should implement procedures for closer monitoring of these cases until final resolution is reached to ensure Medicaid funds are expended appropriately.

RECOMMENDATION #4

We recommend the Department of Public Health and Human Services:

- A. *Comply with federal regulation and implement procedures for referring cases of suspected prescription fraud by Medicaid recipients to appropriate law enforcement officials.*
- B. *Implement procedures related to ongoing, internal monitoring of suspected fraud cases which have been referred to appropriate law enforcement.*

Resolution of Cases Involving Prescription-Related Abuse of Medicaid Not Clear-Cut

While the definition of fraud is relatively clear, the concept of abuse is more obscure. Federal regulations define abuse as recipient practices which result in unnecessary cost to the Medicaid program. This includes a wide variety of activities including actions by recipients which may not be fully intentional. According to department management, the Medicaid program serves a population who may not be able to make appropriate decisions regarding their use of prescriptions for a number of reasons including physical or mental disabilities and mental illness.

The department's options for resolution of cases of abuse, shown in Figure 5, are limited. These include dropping the case due to insufficient evidence, issuing a warning letter to the recipient, and imposing sanctions allowed under the state Medicaid plan. As discussed previously in this report, removal of a recipient from the Medicaid program because of abusive behavior is not permitted under federal regulations. During our audit, we found the department uses DUR edits in the Prescription Drug Card System (PDCS) to limit recipient access to some prescription drugs as a result of recipient actions. In these cases, a letter outlining the restrictions and the recipient's options for contesting the restrictions is sent to the recipient.

In terms of other sanctions allowed under the state Medicaid plan, we identified the department's Team Care program as a means for minimizing the risk associated with recipients who overuse Medicaid services, including prescription drug coverage. During our audit, we identified weaknesses related to this program as a method of case resolution.

Department's Resolution of Cases of Abuse Does Not Provide Ongoing Monitoring

As part of our review of the sample discussed earlier in this chapter, we evaluated how the department resolved the cases and identified weaknesses associated with the department's resolution of some cases in our sample. Based on audit work and interviews with staff, we determined the department's primary method of resolution involving cases in which Medicaid recipients overuse or abuse prescription drugs is enrollment in the Team Care program. Our review showed that this program does not serve as an adequate mechanism for ongoing monitoring of these high-risk recipients. We identified the following limitations:

- ◆ The department does not verify recipients referred to Team Care by the DUR contractor are subsequently enrolled. We identified three recipients in our sample who were referred, but never enrolled, even though they maintained Medicaid coverage for the period in question.
- ◆ The MMIS contractor only maintains records of the individuals enrolled in Team Care since 2010. We identified three instances where a Team Care enrollee lost eligibility for Medicaid and was not reenrolled in Team Care when Medicaid coverage restarted. In all three instances, the recipient was later re-identified for Team Care based on inappropriate prescription usage or continued high-risk behavior.
- ◆ There are instances when recipients cannot be restricted to both one medical provider and one pharmacy. Instead, the department is only able to restrict one or the other. We noted five recipients in our sample where full restrictions could not be invoked.

Other State Solutions

In South Carolina, Medicaid recipients who may be abusing prescription coverage are identified through DUR activities. State officials review recipient drug utilization to determine if the recipient is appropriate for the state's "lock-in" program. This is a program similar to Montana's Team Care Program, in which recipients are required to fill prescriptions at one designated pharmacy. Recipients in South Carolina may be "locked-in" to a pharmacy based on presence of problematic utilization indicators in their use history, such as use of multiple pharmacies or prescribers, a history of misuse, utilization patterns that deviate from peer group comparisons, or drug-seeking behaviors. If, during the state's review, additional coordination of care is deemed necessary, referral to other programs may be made, depending on the recipient's needs. Once the recipient has been enrolled in the "lock-in" program, their prescription use is monitored on a monthly basis and compared to use prior to enrollment in the program.

Controls Needed to Ensure Appropriate Monitoring of High-Risk Recipients

The purpose of the Team Care program is to better monitor the care of recipients identified as inappropriately or excessively using medical services through the restriction of the recipient to one medical provider and one pharmacy. In our sample review, we assessed whether enrollment in the Team Care program provided ongoing monitoring and we determined no active monitoring of these recipients is done by the department. We noted seven instances where recipients were reviewed by Team Care staff; however, all of these instances were in response to a request from the recipient related to graduation from the program or a change of designated medical provider or pharmacy, rather than active case management by the program.

Because of the limited monitoring of recipients identified as high-risk in relation to prescription misuse or abuse, as well as the enrollment-related weaknesses noted, there is increased potential for added costs to Medicaid.

RECOMMENDATION #5

We recommend the Department of Public Health and Human Services establish controls to ensure high-risk recipients identified as abusing the Medicaid prescription program are continuously monitored.

Consistent Tracking Needed to Ensure Appropriate Investigation, Referral, and Resolution of Identified Cases

The ability to access and analyze information about cases identified as potential prescription fraud or abuse is vital for the department as it tracks the status of these cases and ensures case handling complies with federal and state regulations. As we attempted to review department activities related to the investigation, referral, and resolution of cases, we noted the department has limited information about these cases. Information received by department staff about cases is not documented in a single location. Additionally, department contractors may have documentation related to cases, but it is not easily accessible to the department or its contractors and is not in a reportable format. Because of the lack of centralized tracking of cases, it was not possible for the department to determine the number of cases of prescription-related fraud or abuse committed by Medicaid recipients identified during fiscal year 2012.

Examples of Case-Tracking Mechanisms Available

During the course of our audit, we identified examples of case-tracking mechanisms used by other investigating entities. The Department of Justice MFCU uses a database to track all open and closed cases, as well as case events and case status. The database has query and report capabilities so that MFCU management can easily compile data about case activities. In addition, there is an electronic case file for each case, in which all documents obtained during the course of an investigation are stored. The department's PI section also uses a database to track its cases related to allegations of eligibility-related violations. Finally, the Health Resources Division's Managed Care Bureau, in which the Team Care program is located, maintains information about complaints received on a spreadsheet. The document contains details about the complaint, the source, which staff were assigned to each complaint, and how the issue was resolved. There is formal policy about how the document is to be used and how case status should be tracked.

Improvements in Case Information Needed

In our review, we found no formal policies about how information related to potential prescription-related fraud or abuse by Medicaid recipients is to be shared or documented within the department. Department management acknowledges a process for tracking these cases is needed. It was reported the department's failure to track this information may have been due, in part, to staff turnover. Management noted staff in one section may develop an informal process for handling some duty which is known to others in the department, but when there is turnover in staff the process may change and the rest of the department is unaware of the change. However, because we found limited activities overall regarding detection, investigation, and resolution of prescription-related fraud and abuse, we believe there would have been insufficient information to track had program positions remained filled. Once the department implements stronger controls over these activities, case information will be available. Implementation of a formal process for tracking cases of this nature will allow department staff to better communicate about cases and ensure cases are resolved appropriately.

RECOMMENDATION #6

We recommend the Department of Public Health and Human Services implement a mechanism for tracking identified cases of potential recipient prescription fraud or abuse to ensure appropriate investigation, referral, and resolution occurs.

Chapter V – Department Management Of Suspected Recipient Prescription Fraud- And Abuse-Related Activities

Introduction

Given the number of Montanans directly impacted by the Medicaid program, as well as the significant state and federal funds associated with the program, it is important the Department of Public Health and Human Services (department) ensure it effectively handles cases involving potential prescription fraud or abuse. As discussed in the previous chapters, we identified areas where the department's controls should be strengthened. We also identified overarching weaknesses in the department's management of fraud- and abuse-related activities in the following areas:

- ◆ Staff roles and responsibilities related to suspected prescription fraud or abuse.
- ◆ Direction to the Medicaid Management Information System (MMIS) and drug utilization review (DUR) contractors about communication of information regarding potential prescription-related cases of recipient fraud or abuse to the department.

Department Guidance Regarding Suspected Prescription-Related Fraud and Abuse

The Government Accountability Office (GAO) defines internal control as a major part of managing an organization. It comprises the plans, methods, and procedures used to meet organizational missions, goals, and objectives, as well as ensure compliance with state and federal regulations. Under 42 CFR §455.13(a) state Medicaid requires agencies to have “methods and criteria for identifying suspected fraud cases.” These requirements apply to fraud committed by both providers and recipients of Medicaid-covered services. During interviews, department management acknowledged the agency has a duty to prevent fraud and abuse. During audit work, we sought to determine what role the department has assigned to staff and the guidance provided regarding that role. We reviewed agency policy, formal responsibilities assigned to the staff positions most directly associated with the Medicaid Prescription Drug Program (program), and relevant training provided to staff.

Agency Policy Is Not Available

The development of detailed policies, procedures, and practices to enforce management directives is a key aspect of maintaining internal control. We determined the department has no central repository for agency policies; each division is responsible

for the development and administration of its own policies. Because the program is located within the Health Resources Division (HRD), we attempted to review HRD's policies and procedures related to suspected fraud or abuse. Division management reported in multiple instances there are no specific policies or procedures related to the handling of suspected recipient fraud or abuse.

Related Staff Training Is Limited

Another factor in developing a positive control environment necessary for the achievement of an agency's mission, goals, and objectives is management's commitment to personnel competence. All personnel need to possess and maintain a level of competence which allows them to accomplish their assigned duties, as well as understand the importance of developing and implementing good internal control. Management should identify appropriate knowledge and skills needed for various job duties and provide needed training. Because of this, we examined training provided to staff regarding the handling of fraud or abuse.

HRD management reported limited training provided to staff in the division specifically regarding identification, investigation, and resolution of prescription-related recipient fraud or abuse. It was noted some training is provided to staff through attendance at professional organization conferences, but these conferences focus on Medicaid program administration in general and may or may not offer sessions related to prescription fraud or abuse. Management also reported the Department of Justice's Medicaid Fraud Control Unit (MFCU) offered training to department staff in the past; however, this most recently occurred four to six years ago and specifics about the training were not available.

Training Sources Are Available

During audit work, we identified sources of training which might prove useful to the department in training staff in the handling of recipient fraud or abuse. As one example, the Centers for Medicare and Medicaid Services offer training through its Medicaid Integrity Institute to meet the training and education needs of state Medicaid employees. We identified training related to skills and techniques in Medicaid fraud detection, data analysis, and other topics.

Improvements Are Needed in Department Guidance for Staff

Though department management acknowledges the agency's responsibilities related to prescription fraud or abuse, it has not provided direction to agency staff about their role or the role of other staff within the department. We found multiple instances in which staff noted they believed other divisions in the agency were conducting fraud-

or abuse-related activities; however, when we pursued this further, we found these divisions had no duties specific to Medicaid recipient fraud or abuse of prescription benefits. Failure to provide clear guidance has led to increased risk that cases of fraud or abuse are not being identified or resolved appropriately, as discussed in this report. Because of this, the department is not in compliance with federal regulations with regard to its handling of prescription-related fraud and abuse.

RECOMMENDATION #7

We recommend the Department of Public Health and Human Services comply with federal regulations and establish controls over suspected prescription-related fraud or abuse by:

- A. *Implementing formal methods and criteria for identifying, investigating, and resolving suspected cases.*
- B. *Assigning specific related duties to staff through policies and procedures.*
- C. *Providing related training opportunities to staff.*

Direction to Contractors Regarding Potential Prescription-Related Cases of Recipient Fraud or Abuse

As discussed in the previous chapters, the department's contract with the MMIS contractor for pharmacy benefit manager services is included as part of a larger contract related to the development, implementation, and operation of the MMIS, as well as fiscal agent duties. In addition, the MMIS contractor currently administers the department's recipient fraud hotline. The DUR contractor provides services related to DUR, prescription prior authorizations, and pharmacy case management. Because of the services provided under these contracts, both contractors possess information which may be useful to the department as it completes its mandated duties related to potential prescription fraud and abuse.

Current Contract Requirements Are Limited

During our audit, we reviewed the direction provided by the department to the MMIS and DUR contractors related to cases of suspected prescription fraud or abuse by recipients. We assessed requirements included in the contracts between the department and both contractors and interviewed department and contracted staff. We found the department has provided no specific direction to either contractor with regard to how information about questionable recipient behavior related to prescription benefits should be handled.

As part of our assessment, we reviewed the content of both contracts. We found no specific mention of fraud- or abuse-related duties in the MMIS contract. We also reviewed the department's contracts with the DUR contractor. We found no related language in one contract and in the other, noted reference to the federal requirement for retrospective DUR analysis through performance of "monthly statistically valid retrospective analysis of claims based data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Montana Medicaid recipients." However, we found no mention of what is expected of the DUR contractor should potential fraud or abuse be identified through these activities. Managers at both contractors could recall no specific direction provided by the department in terms of the handling of information about potential prescription fraud or abuse by recipients.

Cases of Potential Fraud and Abuse Have Been Identified by Contractors

During our audit work, the DUR contractor's staff identified examples of potential fraud and abuse cases which had been identified during the term of the contract. In addition, they provided statistics regarding encounters with recipient behavior which may not be illegal, but, in their professional opinion, represents risk in terms of potential fraud or abuse. For example, they reported they receive information from local pharmacists regarding approximately twenty to thirty instances of Medicaid recipients paying cash for narcotics prescriptions per month. In general, the occurrence of cash-paying is not reported to the department unless significant funds are involved. While the DUR contractor has the opportunity to identify cases of potential fraud or abuse and does so, staff and management report the department has never provided clear guidance or direction about when or how information about these cases should be reported to the department.

Contractual Relationships May Serve as Tools for Department to Identify Potential Fraud and Abuse

As the department strengthens its controls related to potential prescription fraud and abuse, management should identify the tools needed to aid the department in meeting its required responsibilities as the state Medicaid agency. Such tools might include new reports added to the standard series extracted from the Prescription Drug Card System (PDCS) based on the type of analytics we discussed earlier in this report or information about questionable recipient behavior identified through hotline tips or DUR activities. While the MMIS and DUR contractors have a significant role in the delivery of Medicaid prescription benefits, the department is ultimately the entity responsible for complying with federal regulations and handling potential prescription

fraud and abuse by recipients. Therefore, it is vital the department determine how these contractual relationships can be used to improve controls over potential fraud and abuse.

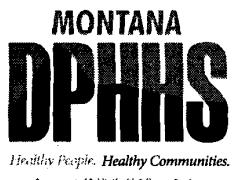
RECOMMENDATION #8

We recommend the Department of Public Health and Human Services:

- A. *Determine how its contractual relationships can be used to detect and identify instances of potential prescription fraud or abuse by recipients.*
- B. *Provide clear direction to contractors regarding when and how information regarding potential fraud and abuse by recipients should be reported to the department.*

DEPARTMENT OF PUBLIC
HEALTH AND HUMAN
SERVICES

DEPARTMENT RESPONSE



Department of Public Health and Human Services

Steve Bullock, Governor

Richard H. Opper, Director

May 24, 2013

Tori Hunthausen
 Legislative Auditor
 Legislative Audit Division
 Room 160, State Capitol Building
 PO Box 201705
 Helena, Montana 59620-1705

RECEIVED
 MAY 28 2013
 LEGISLATIVE AUDIT DIV.

Dear Ms. Hunthausen:

The Department of Public Health and Human Services has reviewed the performance audit “Detection and Resolution of Suspected Medicaid Recipient Prescription Fraud and Abuse” completed by the Legislative Audit Division. Our responses and corrective action plans for each recommendation are provided below.

Recommendation #1: We recommend the Department of Public Health and Human Services make improvements to its data analysis process by documenting and compiling trends and anomalies which may indicate potential prescription-related fraud and abuse.

Response: Concur

Corrective Action: The Department will establish the “mean of use” for drugs identified as having a high risk of abuse or fraud, establish upper limits, formalize analytic approaches and implement procedures to consistently evaluate the data.

Planned Completion Date: November 2013

Recommendation #2: We recommend the Department of Public Health and Human Services increase effectiveness of the Medicaid recipient fraud hotlines and ensure:

- A. The hotline is appropriately advertised to potential user
- B. Staff administering the hotline are trained to identify potential fraud and abuse
- C. Call information is effectively recorded and compiled
- D. Issues identified through hotline reports are resolved appropriately based on state and federal regulations

Response: Concur

Corrective Action: The Department is reviewing existing hotline processes and will implement improvements over the next few months that will ensure hotlines are an effective component of Medicaid program management.

Planned Completion Date: November 2013

Recommendation #3: We recommend the Department of Health and Human Services comply with federal regulations and conduct preliminary and full investigations of cases of potential recipient prescription fraud or abuse.

Response: Concur

Corrective Action: The Department will strengthen operating procedures to ensure that suspected recipient fraud and abuse cases are sufficiently investigated and documented.

Planned Completion Date: November 2013

Recommendation #4: We recommend the Department of Health and Human Services:

- A. Comply with federal regulation and implement procedures for referring cases of suspected prescription fraud by Medicaid recipients to appropriate law enforcement officials
- B. Implement procedures related to ongoing, internal monitoring of suspected fraud cases which have been referred to appropriate law enforcement.

Response: Concur

Corrective Action: The Department will implement procedures that include expectations for referral to law enforcement and subsequent monitoring.

Planned Completion Date: November 2013

Recommendation #5: We recommend the Department of Public of Health and Human Service establish controls to ensure high-risk recipients identified as abusing the Medicaid prescription program are continuously monitored.

Response: Concur

Corrective Action: The Department will implement a new data monitoring procedure which will include continual monitoring of high risk recipients.

Planned Completion Date: November 2013

Recommendation #6: We recommend the Department of Public Health and Human Services implement a mechanism for tracking identified cases of potential recipient prescription fraud or abuse to ensure appropriate investigation, referral, and resolution occurs.

Response: Concur

Corrective Action: The Department is currently reviewing available options for tracking suspected fraud and abuse cases. Once the analysis is complete procedures will be implemented outlining documentation and tracking expectations, from initial report through resolution.

Planned Completion Date: November 2013

Recommendation #7: We recommend the Department of Public Health and Human Services comply with federal regulations and establish controls over suspected prescription-related fraud or abuse by:

- A. Implementing formal methods and criteria for identifying, investigating, and resolving suspected cases.
- B. Assigning specific related duties to staff through policies and procedures.
- C. Providing related training opportunities to staff.

Response: Concur

Corrective Action: The Department will establish formal methods of identifying, investigating and resolving suspected cases of fraud or abuse and will document those methods in clear procedures with specific assignments. In addition, the Department will ensure that sufficient training opportunities are provided to all parties whether employed by or contracted with the department. The department is currently evaluating the use of training specific technology to develop, disseminate and monitor training for department employees.

Planned Completion Date: December 2013

Recommendation #8: We recommend the Department of Public Health and Human Services:

- A. Determine how its contractual relationships can be used to detect and identify instances of potential prescription fraud or abuse by recipients.
- B. Provide clear direction to contractors regarding when and how information regarding potential fraud and abuse by recipients should be reported to the department.

Response: Concur

Corrective Action: The Department will review contractual expectations and implement changes necessary to provide clearer direction regarding fraud and abuse reporting.

Planned Completion Date: December 2013

We appreciate the effort that your staff put into this audit and look forward to using these recommendations to improve operations within the Medicaid program.

Sincerely,



Richard H. Opper, Director
Department of Public Health and Human Services

Cc.

Mary Dalton
Duane Preshinger
Dan Peterson
Marie Matthews